> those whose investments have performed well and those whose turn out to be less well-chosen ... The uncertainty surrounds both the capital sum which will be available at retirement and the rate of annuity which it will purchase. One guide to personal pensions points out that 'annuity rates are also extremely volatile as they relate directly to interest rates and also to the desire of an insurance company to come in or out of the annuity market'." 56/

The legislation establishing the personal pension option includes a number of safeguards to reduce the risk from unscrupulous investment managers or speculative investment behaviour. However, individuals electing this option give up the more certain environment of collective schemes, especially SERPS, for the flexibility, and perhaps greater personal gains, of personal investment.

III. SOCIAL AND ECONOMIC SUPPORT TO OLD PEOPLE WITHOUT FAMILIES

In all countries of the world, the family plays a key role in providing social and economic support for its members. But what happens when there is no family? In the case of the elderly, problems arise when there are no children or other family members to help them in their old age. Programmes and policies must be developed to deal with these problems.

Throughout their lives almost all individuals are integrated into households, families, clans, tribes, communities etc. The many supportive roles of this family solidarity in promoting the security and social viability of both individuals and the larger society have been discussed at length in a large body of literature.*

Thus, when people reach old age, they are likely to have spouses and children who are able to assist them in times of need.** But the extent of potential support for some may be meagre or even non-existent. At least four major events can significantly weaken the support situation prevailing in old age: (a) the death of a spouse, (b) divorce or separation, (c) childlessness or (d) the migration of family members.

A. Older people without spouses

Among older people we find a large proportion in most countries who are not married, that is, who are single, widowed, separated or divorced. Table 8 shows this proportion for 11 countries in the early 1980s. The proportion ranges from 37 per cent in Bangladesh to 53 per cent in Hungary. On average, nearly half of the aged in both industrialized and developing countries do not currently live with a spouse.

Table 8. Proportion of the aged (65+) who are not married, early 1980s, selected countries a/
(Percentage)

Country	Proportion
Bangladesh	37
Greece	39
Philippines	40
Japan	45
Brazil	47
United States	47

continued

*See, for example, Lopata, 57/ Mangen, Bengtson and Landry 58/ and Cowgill. 59/

**To a lesser extent, they also receive assistance from other relatives and members of their community.

Table 8 (continued)

Country	Proportion
India	48
Indonesia	49
Norway	49
Singapore	50
Hungary	53

Source: Calculated from data in B. B. Torrey, K. Kinsella and C. M. Taeuber, An Aging World, International Population Reports Series P-95, No. 78 (Washington, D.C., Government Printing Office, 1987), table 6.

a/ "Not married" denotes men and women who were single, widowed, separated or divorced.

Also, a very high proportion of older women are widowed. Table 9 shows the proportion of the female population aged 65 and over that is widowed, in the nine countries with the lowest proportion and the nine countries with the highest proportion. In the Republic of Korea, for example, 75 per cent of women aged 65 or more are widowed.

Table 9. Proportion of women age 65 and over who are widows, circa 1980 (Percentage)

Country	Highest	Country	Lowest
Republic of Korea	75.4	Haiti	32.0
Morocco	71.1	Cuba	35.2
India	70.3	Ecuador	37.8
Singapore	64.4	Mexico	41.2
Indonesia	63.8	Sweden	42.9
Federal Republic of Germany	61.8	Netherlands	43.4
Malaysia	60.8	Switzerland	43.7
Japan	60.7	Norway	44.0
Hungary	58.7	Brazil	46.3

Source: Based on data in G. C. Myers, "Cross-national patterns and trends in marital status among the elderly", Populations âgées et révolution grise, M. Loriaux, D. Remy and E. Vilquin, eds. (Louvain, Institut de Démographie, Université Catholique de Louvain, 1990), table 1.

Many studies around the world show that loss of a spouse not only significantly weakens the support network that operates in time of need, but also can cause immediate problems for the surviving marriage partner. Often, for

example, the deceased spouse was still working, so a major source of income shared by the couple ends. When pension income is available, it often stops or is reduced drastically when the eligible retired worker dies. In many societies, a woman at marriage leaves her family of birth to join her husband's family and sometimes finds her status and roles significantly eroded after his death; a discussion of what can happen is contained in Ellickson. 60/

Similar problems, sometimes more serious, arise as a result of divorce or separation. Upon divorce, the economic situation is likely to deteriorate seriously, especially for women. Social relations may also become strained, with isolation frequently increasing.

B. The childless

Of course, the children of older people are a major source of support in old age. Even when there is a spouse, but especially if there is none, older people generally count on the assistance of their children in times of need. But the fact remains that many people are childless when they reach old age.

There are four main reasons for childlessness. First, biological infertility affects some men and women. Secondly, children may die before their parents as a result of disease, war, famine, accident etc. Thirdly, some people do not marry or voluntarily choose not to have children. Fourthly, one of the spouses may die before any children are born, with no remarriage taking place.

Statistics on the extent of childlessness among the elderly are relatively meagre. The evidence available, however, indicates that it is a significant factor in developed countries. In developing countries, the phenomenon, while not widespread, is not insignificant. Data for Austria, Canada and the United States indicate that about 20 per cent of the elderly are childless in those three countries. 61/, 62/, 63/, 64/ Linda Martin has recently published information from the WHO surveys of elderly persons in Fiji, Malaysia, the Philippines and the Republic of Korea. 65/ These surveys of persons aged 60 and over 66/ found the following percentages of the older population who had no living children: Malaysia, 3 per cent; Fiji, 4 per cent; Philippines, 5 per cent and the Republic of Korea, 6 per cent.

Data are also available for Argentina and Chile.* In these two countries, survey respondents were asked who would be able to look after an older person in case of illness. Between 4 and 13 per cent reported that no one would be available:

Argentina		Chile	
Females		Females	12%
Buenos Aires	13%	Males	6%
Other cities	7%		
Males			
Buenos Aires	5%		
Other cities	4%		

*Pan American Health Organization data reported in ECLAC. 67/

In both countries, the proportion of women with no one available to provide assistance was at least twice as high as that of men.

From the scattered data available it can be seen that there are older people without children in both developed and developing countries. While these individuals typically constitute a relatively small part of the total population, their existence and vulnerability represents an important concern for every country.

C. Migration

Even if older people have children, there is no certainty those children will be available to provide assistance. An increasingly important concern is the problem created by the geographic separation of the elderly from their children. Over the past century there has been a surge in population movements around the world. The global population living in cities more than doubled between 1950 and 1975, in large part accounted for by younger people leaving rural areas. 68/

Kenneth Tout provides a variety of information on how migration negatively impacts the elderly. He writes of a migration crisis, the seriousness of which "may be increased when the emigration is away from the home country altogether. The generations are even more removed in terms of distance, communication, currency, and cultural environment". 69/ While many younger migrants send money to their parents, some choose not to do so or are unable to do so, given their own precarious financial situations. This point is discussed by Oberai and Singh 70/ and Apt. 71/

In addition to problems arising out of economic migration to urban areas and countries where there are better job prospects, there are the problems associated with natural disasters and political upheavals:

> "The first problem to confront the elder in a disaster situation is that he or she may be left behind by the mass migration. When refugees flooded into Sudan from Central Tigray, an Oxfam report estimated that up to 40,000 elderly people had been left behind without adequate support. Most of these old people were incapable of walking for perhaps two months across rough country to reach the 'haven of relief'." 72/

D. When the family cannot provide

While most children acknowledge an obligation to care for their parents in old age, if needed, responsibility becomes less clear when there are no children or they do not or cannot provide the necessary support. Many countries have laws that legally obligate children to provide support to their parents. Often other relatives provide help, and sometimes neighbours, charities or community groups assist the person in need. Finally, in many countries, there are formal government policies and programmes, such as social assistance, created to deal with this issue.

With urbanization, modernization and international migration on the rise and fertility in many countries on the decline, there is a growing need for countries to think carefully about their policies for those without families. It is not sufficient for policy makers to say, "The family will take care of the elderly in our country". As has been shown, there are many aged without

families, and there are many receiving inadequate support from their families. A report on emerging issues related to population ageing in Asia states the issue this way:

> "Cultural traditions in Asia normally provided adequate and sympathetic support to the aged population, but two types of old persons ... [are] particularly vulnerable. The first ... [are] those who had no children or close relatives to care for them. In a context of limited resources and programmes, highest priority at the national and community levels should be accorded to the elderly who are alone. Other vulnerable old persons ... [are] those affected by migration, either because they ... [have] moved or because their children ... [have] migrated away." 73/

Examples from various countries suggest some policy options.

E. Country examples

1. India: help for the destitute elderly

India provides economic and social support to many workers in the formal sector, i.e. the organized, urban work force, by means of a national medical care scheme, provident funds and various employer liability schemes. For the poor in both urban and rural areas, however, there is a lack of formal programmes providing systematic protection from economic insecurity during the various stages of life. Thus, if self-help or family support is not available, older people in India, as in other developing countries, are often confronted with the terrible uncertainty of how to survive.

The central Government and the state governments of India have been very sensitive to this problem. But in the context of the nation's struggle to develop, more help was often promised in both the formal and informal sectors than could actually be provided. As Sahdev Wadhawan points out: "... the social security measures ... and public assistance programmes [in India] have been somewhat restrictive, minimal or cosmetic in their impact and approach, circumscribed as they are by a variety of limitations and constraints". 74/

Acknowledging these harsh realities, it is still true that India has created a variety of innovative income maintenance programmes that seek to be responsive, in greater or lesser degree, to the need of poor people for greater economic security. With regard to the formal sector, the task has been left primarily to the various Indian state governments.* The destitute elderly are covered by various state social assistance programmes, often specially targeted to help deal with the needs of the destitute aged.

One major programme in Maharashtra state illustrates how this issue is dealt with in India. Maharashtra is located in southern India and has a population of about 70 million people, almost two thirds of whom live in the rural areas. The social assistance programme for destitute elderly provides

---

*An important exception is the group of central labour welfare funds set up by the Ministry of Labour of the central Government to provide health care to certain occupational categories, e.g. miners of mica, limestone, iron and manganese.

benefits to those aged 60+ (women) or 65+ (men) who (a) have no property or any other significant source of financial support, (b) cannot receive financial support from a spouse, son, or son of a son (aged 18 or older) and (c) have resided in Maharashtra for at least 15 years.*

At the end of 1987 there were 273,486 recipients of programme benefits. 75/ Benefit levels under the programme, however, are very low; some would say they are too low to provide even the necessary minimal relief appropriate to meeting recipients' needs.**

The Maharashtra programme is administered by the state's Housing and Special Assistance Department. The state is divided into administrative areas, and in each there is an area committee consisting of five non-official members appointed by the Government. These area committees have authority and responsibility for general decisions related to eligibility and for overseeing the disbursement of benefit assistance funds. However, applicants can appeal adverse decisions to a state-level committee composed of both government officials and non-government persons.

Social assistance programmes currently also operate in most other states of India. Qualifying ages vary from 55 to 65 years, and, as in the state of Maharashtra, the qualifying age is sometimes higher for men. States vary as to specific eligibility conditions, but the means test for financial resources is very strict in all of them.

Provisions pertaining to the responsibility of relatives have been relaxed significantly in many states over the years, and "while distant kins are usually no longer expected to undertake the task of supporting the needy dependents, the obligation on near relations have been maintained". 76/

The existing social assistance programme in Maharashtra and in the other states of India does not completely solve the problem of how to support the destitute elderly. But this type of programme does represent an explicit recognition by one nation of an important problem that faces every nation. And it demonstrates a particular country's commitment and resolve to do something about the problem. That India falls far short of any optimum solution is regrettable but also understandable, given the economic priorities and constraints in a developing country. However, perhaps more important is the fact that the Indian programmes go far beyond those in many other developing countries, some of which are much more economically prosperous.

---

*The physically and mentally disabled and widows are also eligible for this programme at any age, if they satisfy all the other eligibility conditions. Excluded from the programme, however, are persons housed in institutions run by private or government social welfare organizations.

**In 1988, the benefit was 60 rupees per month per person, subject to a maximum of 150 rupees per family if there were more than two destitute persons living together.

2. Zimbabwe: residential care for the destitute elderly 77/

The traditional provision by families of care to the frail elderly in Zimbabwe has weakened in recent years. Many rural workers have gone from their rural villages to take employment in the mining industry and in commercial agricultural enterprises that had been set up under the colonial Government. Also, the urbanization and industrialization that is taking place in the country have encouraged the creation of nuclear families away from rural areas. As Nyanguru states, "With the departure of the able-bodied workforce from the local villages, rural Zimbabwe society began to lose its economic viability ... As a result of the declining rural economy and the lack of an adequate social security system in urban Zimbabwe, many of the nation's elderly face severe economic hardship". 78/

The rising number of destitute elderly who have no financial resources, and many of whom have no shelter, convinced a growing number of community leaders and social welfare professionals of the need for an elderly support programme. The Government responded by developing a comprehensive approach to care for the destitute elderly. This approach recognizes that the health and other needs of the destitute elderly vary widely and that a multi-level set of programmes is appropriate. For elderly persons living at home, the goals are to provide pensions, day care centres, visiting district nurses and well-person clinics. For those living at home but in need of more assistance, Scheme A seeks to provide access to a local warden, who can respond to the special needs.

However, many of the destitute elderly have no home or are unable to live independently. For them, the goal under Scheme B is to provide hostel accommodation, which include meals, laundry services and a variety of general care services. Scheme C seeks to provide nursing care and assistance with the tasks of daily living, such as toileting and dressing, to those elderly who are seriously incapacitated.

While the Government of Zimbabwe recognizes the growing problem and the need to move forward on providing care alternatives, resources for implementation are limited. As a result, the number of residential homes under Scheme B and Scheme C are still very limited in number.

Nyanguru reports on two care facilities operating under Scheme B: the Kudzai Old People's Home and the Dambudzo Old People's Co-operative. Kudzai is 25 kilometres from Harare city, while Dambudzo is in a farming area that is 40 kilometres from Harare. The physical facilities and staffing are very different in the two institutions. Comparatively speaking, Kudzai is a resource-rich facility. It has indoor toilets and baths, beds, a dining hall and a well-equipped clinic and it is not overcrowded. Dambudzo has outdoor toilets and baths, mattresses without beds and no dining hall; a doctor visits once a month and the number of occupants per room is twice as great as at Kudzai.

The two facilities also operate very differently. The residents of Dambudzo are actively involved in growing food and raising the animals used for food. They prepare and serve the food. They are encouraged by the cooperative rules to actively participate in governance. Many of the residents are engaged in money-making projects such as weaving mats. In contrast, Kudzai is run by a church organization and has a paid staff that cooks, cleans and cares for the residents. While some individuals produce and sell goods, such activities are less common, and no commercial work is undertaken.

After having interviewed almost all the residents of both facilities, Andrew Chad Nyanguru of the Harare School of Social Work concludes that both facilities provide good basic shelter and care to older people requiring an alternative living environment. While the physical facilities at Kudzai are better than those at Dambudzo, Nyanguru's interviews indicate a much higher level of satisfaction among the Dambudzo residents. Nyanguru concludes that the cooperative organization encourages greater participation, self-reliance, and social contact, resulting in higher satisfaction levels.

The experience of these two facilities in Zimbabwe for destitute elderly persons indicates that relatively inexpensive and less institutionalized approaches may provide more, not less, satisfaction among the old people they serve. As Nyanguru observes:

> "Contemporary practice in the care of the aged has stressed the provision of physical facilities for the elderly. Generally, this has meant that older people have things done for them. Throughout the developed world, relatively expensive homes with sophisticated infrastructures are built and staffed with paid employees. However ... [the results of this Zimbabwe study] serve to underline that provision of food, clothing, and shelter is insufficient to ensure a satisfactory quality of life for the elderly in residential care facilities ... [Policy] should emphasize continuity in the conditions of life, opportunities for self-help, participation in the day to day running of the home and democratic decisionmaking, all of which enhance the individual's sense of dignity and self-worth." 79/

3. Union of Soviet Socialist Republics: new social assistance initiatives 80/

In recent years, there has been increasing recognition that there needed to be a fundamental overhaul in the USSR of the programmes providing assistance to people with low incomes. A large part of the problem was the many millions of elderly people receiving very low pensions. Before the benefit reform of October 1989, over 23 million pensioners, or 40 per cent of all pensioners, received less than 60 rubles a month, roughly a quarter of the average national wage. In fact, about 90 per cent of the people with very low pensions received the minimum pension, which at the time was 40-50 rubles per month. At last count, there were over 25 million persons living on pensions in households where no one was working. And about 10 million elderly and disabled persons lived alone.

As observed by Tsivilev and Rogogin:

> "These statistics are alarming. The moral standards of a society are judged by, amongst others, its attitudes towards the elderly ... [Soviet] society is now going through a process of re-examining its moral standard, and this is emerging as one of the key factors in the restructuring of our life. The Government's efforts at providing social protection for people living alone are increasingly being accompanied by initiatives taken by the population at large ... New forms of social assistance were developed for the elderly, especially those living alone. Nowadays, we are witnessing examples of charitable acts throughout the population. Society has come to understand the immorality of the indifference it used to show to pensioners and has set about putting wrongs to rights and paying its debts." 81/

The 27th Congress of the Communist Party of the Soviet Union and the 19th Party Conference started the process of overhauling government policies on social security and social assistance. In June 1989, the Congress of People's Deputies of the USSR raised the level of the minimum pension so that it equalled the minimum wage, 70 rubles per month. And on 1 January 1991, a new USSR pension law went into effect.

This new pension law gave the republics, local soviets of people's deputies and work cooperatives the right to establish at their own expense additional forms of in-kind assistance and to grant supplementary help with rent and services payments. Also, for the first time, social pensions were provided for non-working citizens who were not entitled to a retirement pension. Such pensions were made available for (a) people who had reached the pensionable ages of 60 (men) and 55 (women), (b) certain categories of the disabled and (c) children in families without a breadwinner. On 30 May 1990, Izvestia reported that one of the most significant provisions of the new law was the linking of the minimum pension to the minimum wage, the latter being adjusted for changes in the cost of living.

New programmes were also established to provide home help to elderly and disabled people living alone. Assistance was also provided to some married couples who were either partly or totally unable to manage alone and who needed constant assistance with housework, taking medication, cooking etc. Such services were set up at the district, municipal and borough levels of the social security network. For example, more than 87 divisions of home help services are currently operating in Moscow, providing services to about 5,000 people. The services are provided without charge and include such things as the delivery of meals, assistance with personal hygiene, laundry and dry cleaning services, the paying of bills and assistance in obtaining medical care and legal advice.

It is estimated that there are approximately 850,000 people needing daily assistance of some type. Unfortunately, at the present time only about one third of these people receive any assistance. A major obstacle is the lack of funds to expand services.

Given the continuing need for greater income and service support to the low-income population, there has also been a revival of voluntary giving in the various republics. The number of charities began to grow rapidly in the latter part of the 1980s. Social assistance foundations have become one mechanism for organizing charitable activities. Private individuals, work cooperatives and public social organizations can participate in their operations. For example, many cooperatives channel up to 15 per cent of their profits into social assistance schemes.

The Doctor Hause Foundation in Odessa illustrates one non-governmental approach to the existing problems. The Foundation receives donations of between 300 and 1,000 rubles a month from about 40 cooperatives. It is estimated that of the 30,000 pensioners living in the Primorsky district of Odessa, 10,000 receive less than 60 rubles a month; of these pensioners, 700 live alone and 200 are totally disabled. The Foundation provides free meat products and other food, pays the rent, buys clothing or provides financial assistance to many of those in need. The Foundation also employs several social workers to assist people. Recently, at the initiative of the Foundation, the city of Odessa set up an old age home for the elderly. The home will be financed from contributions of the local government, the Foundation and the Church.

IV. FAMILY SUPPORTS AND THE ELDERLY

The International Plan of Action on Aging places high priority on the development of policies that will both strengthen and complement family supports for older people:

> "As the family is recognized as a fundamental unit of society, efforts should be made to support, protect and strengthen it in agreement with each society's system of cultural values and in responding to the needs of its aging members ... Appropriate support from the wider community, available when and where it is needed, can make a crucial difference to the willingness and ability of families to continue to care for elderly relatives." 82/

What we have seen in recent decades is the concurrent phenomena of decreasing family size, increased numbers of older people and rising numbers of the very old, who often require extensive health and social supports. These changes put increasing pressures on the family, which is also changing. Even as the demands on the family increase as a result of demographic ageing, the family as an institution in society is under significant stress as a result of marital instability, increased geographic mobility, limited economic capacity and changing attitudes about family obligations, all of which issues are elaborated on in McDonald. 83/ One unfortunate result is that "the development of the urbanization process and the increase of industrial progress lead many people to live in cities in anonymity and loneliness within the nuclear family". 84/ Fortunately, despite all the problems, evidence indicates that many families continue to function well, providing economic and social supports to various family members in times of need.

Still, it would be a mistake to view the family as operating in isolation from and without the support of key community and government institutions. Over time, formal institutions have been given additional responsibilities for assisting families, sometimes taking over their traditional responsibilities. While this trend can be expected to continue, it is important to view these developments as efforts to supplement and support the family and its traditional roles, not as a deliberate policy to supplant the family.

One concern arises, however, as the provision of outside assistance increases: that the provision of too much outside assistance will prove counterproductive, weakening roles and responsibilities better maintained by the family. In fact, some social policies relating to the elderly have proven dysfunctional, tending to isolate older people from their families. Thus, an important task is to find a good balance between family and government assistance, that is, to help the family continue to be responsive to the needs of its elderly members but to provide outside support and care when required.

A. The roles of the aged in families

> "The family is the first and the most important socializing institution, where shelter and security are to be found when facing difficulties in life ... It is found in all societies and at all times, in various forms, structures and compositions. The family ... is a living social institution affected by socio-economic factors as well as by transformations that shape the social environment in which it functions."
>
> from Strengthening the Family: Guidelines for the Design of Relevant Progammes. 85/

The concept of family is not easy to precisely define. It has no standard and unambiguous meaning from one culture to another. Three intermingled and overlapping relationships are commonly used, however, to designate the individuals constituting a family. These are consanguinity (i.e. relationship by blood), marriage and common residence. 86/ The extent to which any one of these factors influences and defines the family relationship varies from one culture to another.

As Cowgill points out, "the status of older people vis-à-vis their grown children varies widely around the world. This ranges all the way from an authoritarian or domineering relationship toward their children to a complete reversal of role, resulting in abject dependence of the parents on their children". 87/ While the nature of the authority and power relationships varies among its members, the family remains a key mechanism for nurturing, for distributing, and redistributing, economic resources, for dealing with and protecting family members from a variety of economic insecurities, such as disability, widowhood and unemployment, and for providing basic shelter and the dominant living environment.* Thus, the family has been, and remains, critical in the provision of support when people become old and threatened by economic deprivation, disability and social isolation.

Many examples and statistics could be given to show the extent of family supports provided to the aged in both developed and developing countries. Cattell, for example, recently reported on the situation in rural Kenya, basing her findings on interviews carried out from 1983 to 1987. 88/ Cattell's data for 200 women and 216 men indicate that 92 per cent of the women and 88 per cent of the men received help from at least one child. This assistance included, in order of importance, non-money gifts of various kinds, money and services, such as fetching wood and water, preparing food and repairing the house.

In developed countries, families continue to remain a very important source of support in old age. Higher per capita income levels and pension programmes, both public and private, in these countries allow greater independent living among the elderly. However, when older people become frail and lose some or all of their ability to provide for themselves, the family often assumes responsibility for assistance. "Research as well as experience continue to affirm that the family [in developed countries] is the major provider of care for the elderly. Studies [in the United States] have shown that approximately 80 per cent of the elderly, dependent in functional activities of daily living, are receiving care from family members. In Israel this figure reaches 86 per cent in some areas where research has been conducted." 89/

B. Family patterns

It is a widely accepted belief that the process of industrialization leads inevitably to the breakdown of the extended family and its replacement by the modern nuclear family. However, research on the family in recent years questions this conclusion and indicates that the matter is much more complicated, both historically and in terms of what is happening in developing countries today. 90/, 91/, 92/, 93/ The extended family never was the dominant

---

*For a more exhaustive list of family functions, including many non-economic functions, see Mangen, Bengtson and Landry. 58/

family type in some countries, and in some countries where it is, it does not appear to be diminishing in any significant way, even in the face of industrialization and modernization.* In still other countries, changes are indeed occurring, with "the extended family as a traditional household unit ... generally disintegrating in the face of modernization, industrialization, and urbanization, leaving the practice of extended living mostly in rural areas of these countries". 95/

Given the complexity of evolving family structures in various countries, a great deal of caution is required in developing policies regarding ageing and the family. As pointed out by Kendig, Hashimoto and Coppard, policy discussions today are all too frequently "based on unsubstantiated generalizations about the supposed abandonment of the aged by families in developed countries, or of older people being left behind by rapid social change in developing countries". 96/ Again, the reality is much more complex in both types of countries.

What is perhaps most clear is that the pressures created by the promotion of economic growth, together with the severe resource constraints confronting developing countries, have caused many countries to put heavy emphasis on the potential role families can play in dealing with the insecurity and diminished capacity often arising in old age. But as Chawla observes, the family is expected to deal with the challenges of ageing precisely at "the moment when it is under severe and virtually implacable pressures all across the developing world". 97/

C. Policy strategies

How should Governments react to this dilemma? Countries are faced with a strong desire to strengthen the capacities of families to deal with the problems and needs of older people, together with the new problems of ageing populations, at a time when the families themselves are often in crisis. If the proposition is accepted that the expansion of government policies and programmes can effectively supplement and support families in their traditional roles without supplanting them, then government action becomes a necessity. The evidence from the developed country experience strongly indicates that government programmes for the elderly have not generally diminished in any significant way the willingness of families to provide economic and social support to older members of the family who are in need. 98/, 99/, 100/ Government approaches to action should take this into account.

Habib and Factor have classified the approaches Governments may take to family policy into three broad categories. 101/ They call them the obligation, willingness and compensation approaches. In the obligation approach, the family is viewed as obligated to provide care according to its capacity. Given that primary responsibility is deemed to rest with the family, the Government's need to provide supplemental formal support arises from the fact that not all the elderly have families and that some families are not capable of providing sufficient support. In this approach, the emphasis is on incentives and sanctions to encourage families to meet their obligations.

---

*For an excellent discussion of the "quiet revolution in the demography of intergenerational family life", see Bengtson, Rosenthal and Burton. 94/

In the willingness approach, the State supplements the assistance that the family is willing to provide. With this approach, the family that is willing and able to assist the elderly is given less assistance than the family that is unwilling or unable to provide much help. Thus, one of the most important roles for the Government in this approach is to help the elderly and their families, e.g. by means of professional counsellors, to better define what they are willing and able to do by themselves.

In the compensation approach, the Government provides assistance (compensation) irrespective of the family's willingness to support the elderly and irrespective of the support actually provided. Cash assistance payments, not in-kind benefits, are typically provided under this approach.

Combinations of these approaches, of course, are possible. In the matter of providing long-term care to the frail elderly, for example, "it appears that a two-tier strategy has developed in most countries with cash attendance benefits existing alongside home care programs within the health and social services ... The major disadvantage of this mixed strategy is the difficulty in creating coordination between programs operated in different administrative contexts at both the policymaking and field implementation levels". 102/

Few people would argue that public policy should force older people to live with their children. Rather, government tax, housing and income maintenance policies can be designed so as not to discourage shared living arrangements while also promoting choice. For example, Hong Kong public housing policies in the past required children to move out of the public housing unit when they got married. Recent changes in policy now allow one married child to stay on in cases where the elderly parents need support and care. Also, preference is given under current policy to new applicants for housing who are willing to include their elderly parents as members of the household. 103/

More generally, family ties are strengthened when government policies are responsive not only to issues of adequate space and faculties in housing, but also to the need for supportive community services to supplement the home care so willingly given by family members. Of course, as the example from Hong Kong illustrates, to combine the complementary roles of the family and community care is easier said than done.

Another way that Governments can help is to be supportive of employer-sponsored benefits that assist families. The dramatic rise throughout the world in the formal participation of women in the labour force raises an important issue: How are the tasks of caring for children and the frail elderly to be carried out as women spend more time outside the home? Some employers, especially in developed countries, have begun to provide various types of family care assistance for workers.* These include the establishment and operation of day care centres for children, assistance in meeting the monetary burden of outside child care and the provision of special time off for parenting responsibilities.

---

*For example, in the United States, 3 per cent of workers in medium and large firms were covered by programmes allowing time off, paid or unpaid, to care for an elderly dependant. 104/

With regard to the elderly, many employers now see the need to complement government programmes for long-term care with employer programmes that assist working care givers. This assistance can take a variety of forms: personnel policies that permit more flexible work schedules; allowing workers to take time off, sometimes with pay, to care for an elderly dependant; promoting and providing assistance to support groups to help workers deal with the emotional and logistical issues of care giving; establishing dependant care reimbursement accounts to help with care expenses; and helping to establish high quality information and referral services for professional advice.

In many countries, the family is evolving from a male-supported group to one in which very often both parents or a single parent works. Given the desire of most families to continue caring for children and frail elderly persons, there is a need for both Governments and businesses to develop innovative programmes that meet the changing needs of these new kinds of families.

D. Country/area examples

1. Austria: helping with family care expenditures 105/

The social security system in Austria has three major components: social insurance, social care (assistance to war victims) and social assistance. While social insurance is mainly financed by contributions from insured persons and employers, social care and social assistance are financed from general taxation.

Social insurance is the primary programme in the Austrian social security system; it is responsible for 93 per cent of total expenditures, with 2 per cent of all expenditures going for social care and 5 per cent for social assistance.

The proportion that social care and social assistance represent of total expenditures on social security has gone up in the last few years, from 3 per cent to the current 7 per cent. One of the reasons for this is the increasing cost of care for very old and/or dependent persons. This increase comes, on the one hand, from the fact that Austrian families have found it more difficult to look after disabled dependants themselves, especially given the growing tendency for women to take up jobs outside the home, and, on the other hand, from the sharp increase in the number of old people.

The fertility rate in Austria has for some years now been below replacement levels. This development is particularly significant for the care of very old persons. Already about half of the older persons in Austria are living alone or in families without children. As they grow older and frail, many of these people must depend on outside help.

Of those Austrians aged 75 and over in 1987, 27 per cent were receiving daily help with their food purchases, 30 per cent with cooking and 25 per cent with cleaning. The smaller the locality, the more support older persons receive from relatives. In 41 per cent of the cases, such support came from a daughter, in 24 per cent, from a daughter-in-law.

Under the Austrian Constitution, both legislation for social insurance and its implementation are a federal responsibility. The provinces are primarily responsible for providing social assistance. Federal legislators have, however, transferred an important benefit to social insurance: the provision of supplements for dependent persons under pensions insurance.

The dependent person's supplement became a part of pension insurance for workers and salaried employees as a result of the General Social Insurance Act, which became effective on 1 January 1956. Subsequently, the benefit was extended to the pension insurance schemes for the self-employed and for farmers.

The purpose of the supplement is to at least partially reimburse the additional expenditures for services incurred by pensioners who, because of mental or physical disabilities, are not able to cope with daily life. The way in which the supplement is used is solely determined by the pensioners themselves. The care providers have no formal legal entitlement to receive the dependent person's supplement.

The persons entitled to this supplement are recipients of a pension under the pension insurance scheme who need constant care and attendance. The dependent person's supplement can be granted to the pensioner only, not to a husband or wife.*

The dependent person's supplement is paid at the rate of half the pension, subject to a minimum, in 1989, of 2,542 schillings and a maximum of 2,784 schillings. The minimum amount is raised annually by the full pension adjustment factor, which corresponds to the increase in the earned income of non-self-employed active persons in the previous year. The maximum amount is increased by only half the adjustment factor.

The need for attendance and care is considered to be constant if these services are required not necessarily daily but at repeated short intervals. If the assistance is needed only occasionally or can be postponed, the pensioner does not qualify for the benefit. "Attendance" refers to the provision of services that are needed within a relatively short space of time and that are essential to protect the pensioner against deteriorating health or infirmity. This includes dressing and undressing, washing the body, preparation and consumption of food, alleviation of poverty and the heating of the living accommodation.

"Care" refers to all support measures that must be taken, not daily but regularly, that are absolutely necessary to ensure the person's continued existence. This includes essential cleaning of the home, the preparation of food and other necessities of daily life, the handling of money and washing small items.

The principle underlying the definition of dependence implies that there is both a need for attendance and a need for help. From the legal point of view, it does not matter whether the pensioner is living alone or with a spouse or in a family. When the medical certificate needed for eligibility is requested, account is taken of the pensioner's functional condition and, in addition, the location of the home, its proximity to public transport and a food shop and the location of the toilet and fresh water.

The annual expenditure for pension supplements was 8,300 million schillings in 1987. While the number of dependent pensioners rose by 31 per cent

---

*In most provinces, the legislation governing disability and social care provides an allowance for persons in need of care who are not entitled to the dependent person's supplement from the statutory pension scheme.

from 1977 to 1987, expenditures for the dependent person's supplement rose by 117 per cent over the same period.

2. Hong Kong: family and community care 106/, 107/

While most of the elderly in Hong Kong live with family members, usually their children, there is a clear tendency for increasing numbers of young couples to live apart from their elderly parents. Given this trend and the fact that there are sharply rising levels of labour force participation among younger women, the Government has recognized the need to assist families with family care.

In 1972 the Government set up a working party to review the changing situation. The working party reported in 1973 and called for a significant shift in government policy. In brief, it called for introducing care in the community as a future guiding principle for policy. By this, the working party meant that ageing "services should be aimed primarily at enabling the elderly to remain as long as possible as members of the community at large, either living by themselves or with members of their family, rather than at providing the elderly with care in residential institutions outside the community to which they are accustomed". 108/ The services referred to included community nursing, home help, day care, laundry and food services, social and recreational activities, hostel accommodation and sheltered employment.

Before the working party made its report, the attitude of the Government was that the responsibility to care for the elderly must fall on the natural family unit, in particular on their children. It argued that nothing must be done by the Government that might "accelerate the breakdown of [this] natural or traditional sense of responsibility". 109/

The new government policy was adopted in 1977, when the Government published a policy paper on the future development of services for the elderly and generally accepted the recommendations in the working party report. This change in policy was encouraged not only by the growing number of elderly in Hong Kong but also, and more importantly, by the recognition that an increasing number of families were failing to meet the needs of their elderly members.

The approach that guided the development of services for the elderly was officially designated as "care in the community". The purpose of providing community support services was seen as not replacing the family but as helping to meet the needs of those people who had no family to rely on or for whom family support was inadequate. Family support and community support were viewed as complementary to each other, especially when the elderly are so frail that they impose excessive demands on their families.

A wide range of community support services has been introduced in Hong Kong since the "care in the community" approach was adopted. For example, a day care programme was started in 1979 on an experimental basis. An evaluation of the programme found that the elderly receiving the service improved their relationship with other family members, who were freed from the burden of caring for them during the day. The improvement was particularly marked for those from low-income families, because the individuals who had been caring for the elderly could now work to supplement the family's income. 110/

As in other regions and countries, however, the implementation of the community care approach in Hong Kong is limited by the Government's ability to

provide the necessary services. Around the world, the demand or need for services typically far exceeds the supply. This has also been the situation in Hong Kong. In his assessment of the situation, Chow succinctly summarizes the situation and concludes:

> "There is no doubt that the 'care in the community' approach adopted in Hong Kong has only partially achieved its objectives. The failure is mainly caused by the inadequate provision of community support services which leaves as a result most of the families having elderly members without the necessary support. In other words, community support services are not playing a supplementary role to family support as they are intended to be. The two systems of formal and informal support are not therefore complementing each other to form a 'caring community', for the elderly ...
>
> "The fact that the 'care in the community' approach in Hong Kong has largely failed to achieve its objectives does not imply that it has to be replaced by another one. The approach recognizes at least that the great majority of the elderly in Hong Kong are living in the community and most who need care are receiving it from their families. While not excusing the government from its responsibilities, it has to be acknowledged that the inadequate provision of community support services is almost universal and is not special to Hong Kong." 111/

3. Singapore: encouraging family care for the elderly 112/

To encourage the family to care for its elderly members to the fullest extent possible, the Government of Singapore has introduced the following measures:

(a) Intergenerational coresidence. Married children and their parents are allowed to apply for adjoining public flats. Their applications are given priority in the allocation process;

(b) Income tax relief. Income tax relief of 2,500 Singapore dollars ($S) is given to a person who is caring for an elderly dependant, provided that the latter is not earning more than $S 1,500 a year. Moreover, children can claim tax relief of up to $S 6,000 a year for the equivalent sum of money they have contributed to their parents' provident fund accounts;

(c) "Moral education programme". The Government has initiated changes in the school curriculum to strengthen traditional family values and inculcate filial piety and respect for the elderly. An annual Senior Citizens Week is being organized to promote the contributions and status of the elderly. A family life education programme has also been implemented to promote harmonious family living;

(d) Community-based services. To help reduce the burden of care on the family, services such as home visiting, day care and respite care are being offered. The Government has also launched various initiatives to promote as much community involvement in these services as possible. Two objectives are emphasized. First, the elderly should be kept fit and healthy, capable of full participation in the mainstream of community life. Secondly, the aged sick are to be provided supportive services that will enable them to live with their families for as long as possible.

V. THE SPECIAL PROBLEMS OF OLDER WOMEN

> "When I was young, I heard my father say to my mother, 'what do you know about it? You're only a woman'. And I remembered that. I vowed no one was going to say that about me. At that time, girls were expected to get married. Education and careers were not important. We were expected to be carers, loving wives and mothers - always putting others first. We were brought up to feel devalued, not worth much."
>
> Micky Lewis, statement at a conference. 113/

As Micky Lewis' observation (see box) suggests, the special problems confronting older women have their origins, in part, in very early life. The problems of older women are not so much a product of the ageing process per se as they are a product of widespread perceptions of the inferior status of women throughout the life cycle.

A. Economic vulnerability

As pointed out by Under-Secretary-General Margaret J. Anstee, "We must not forget that the situation of older women cannot be separated from that of women in general." 114/ Older women throughout the world are more likely to be living in poverty than older men. To understand why, the economic realities facing women before they are old must be looked at. When an older woman is married, her economic situation typically depends directly on the joint economic activities of both spouses before they become old. Alternatively, when an older woman has never married, is divorced or becomes a widow, her economic situation in old age typically depends very much on her own earlier years of economic activity. In both cases, income in old age depends primarily on savings out of earlier income or on public and/or private pensions. In the case of pensions, the retirement benefits are usually calculated at least in part on the basis of pre-retirement earnings and on the years of creditable service. According to Hofferth, 115/ Corcoran, Duncan and Ponza 116/ and Schulz and Myles, 117/ women are typically less able than men to accumulate adequate savings or achieve a good pension, given some harsh realities:

(a) Women often do not work in the formal labour force due to home-making and child-bearing responsibilities; if they do work, their careers are often interrupted and limited by these and other family responsibilities;

(b) Women generally face severe labour force discrimination and are often forced or steered into the lowest paying jobs, i.e. there is widespread occupational segregation all over the world;

(c) Women generally are less likely to be covered by pensions, tend to have fewer years of creditable service and have earnings histories that put them at a disadvantage in the pension benefit calculation process.

The result is that women in almost all countries approach the task of income provision in old age from a fundamentally disadvantaged position. Poverty among women in old age is not the result of a random or accidental process. It is in large part a result of the fact that most societies relegate women to inferior economic positions throughout their lives.

B. The economic perils of long life

In every developed country, women, on average, live longer than men. 118/ The difference is 5-7 years in most countries and has been widening over the past several decades. Both life expectancy at birth and mortality differentials, particularly at the older ages, have been widening between men and women.

In developing countries, "differences in life expectancy by sex are usually smaller ... than in developed countries. The typical worldwide pattern is even reversed in a few developing societies of South Asia and the Middle East, where the interplay of various cultural factors (including low female social status and preference for male versus female offspring) contributes to higher male than female life expectancy at birth." 119/

One important result of these differences in life expectancy is the fact that a much higher proportion of older women (than men) are widowed. Around the world, widowhood is a reality for increasing numbers of women. As was shown in table 9 (part three, chapter III), the per cent of women aged 65 and over who are widows, for example, is 75 per cent in the Republic of Korea, 70 per cent in India, 61 per cent in Japan, 44 per cent in Switzerland, 41 per cent in Mexico and 35 per cent in Cuba (table 9).

Widowhood often causes problems. Perhaps the most serious is the relatively high probability in almost all countries that when a woman becomes widowed her economic situation will deteriorate seriously. As was discussed previously, it is common, especially in developing countries, for the deceased husband to have been working before his death; the result is that an important source of income shared by the couple suddenly stops. Also, when public or private pension income is being paid, the pension often stops or is reduced drastically when the eligible retired worker dies. In some countries, any benefits received by widows are seriously eroded over time by inflation. Thus, in many countries the majority of widows are poor.

C. Mental and physical health

It is not just economic deprivation that threatens women when they become widowed. The grief and loneliness that come with the death of a spouse, male or female, can be overwhelming, often adversely affecting health. As Bengtson, Rosenthal and Burton observe "... widowhood is a profound life-course transition, bringing a number of losses and changes in objective and subjective levels. Widowhood has negative effects on health, exhibited in higher rates of depression, mortality, and mental illness". 120/ (Bengtson, Rosenthal and Burton cite Pearlin and Johnson 121/ and Gove. 122/, 123/) Widowhood is also likely to cause changes in social and friendship networks and social participation: a widow interacts with different and often fewer people.

These problems of mental health associated with old age, death and dying occur in both developed and developing countries. A study of 100 people aged 60 and over at Patna, India, found that 26 per cent "often felt lonely" and another 25 per cent "sometimes felt lonely". 124/ A study by Ellickson of two villages in Bangladesh reports on the family treatment of widows. 125/ Ellickson writes that she never saw elderly widows mistreated in their sons' homes, but she did see a definite change in interactions upon the death of the elderly husband. The elderly widow changed from an "officious, vocal, wifely head of the domestic realm" into an "old widow, much quieter in voice and demeanor".

Scattered evidence indicates that "... women [in developed countries] report a higher frequency of health problems and disability. However, men predominate in severe disability and in some serious health conditions such as heart disease, emphysema, and, probably, the virulent types of cancer ... Women are [also] greater users of ... [health services] at all ages." 126/ There is also a big difference between men and women in the utilization of nursing homes. In the United States, for example, nearly three quarters of nursing home residents are women. 127/

Research to date does not adequately explain why there are more women than men in nursing homes. Probably, however, the reasons are as follows: (a) women live longer and hence predominate at the older ages when institutionalization is more likely to be needed; (b) women are more likely to be living alone and to be poor and hence are less likely to have access to or be able to afford support services at home; and (c) women are more likely to suffer major functional disabilities and limiting conditions that require care found in an institutional setting (the need for feeding assistance, serious problems of urine control, of mental disorders etc.). 128/, 129/

D. Women and the giving of care

Women not only often need special care when they grow older, they are themselves also the main givers of care. This happens, in part, because women tend to marry men older than themselves and tend to live longer than their husbands. However, a more fundamental reason is the fact that the giving of care is viewed in most cultures as women's work.

Even in developed countries today, care giving remains largely a responsibility of the family. As Chappell observes:

> "Historically, it is a new experience for industrialized nations to have large proportions of elderly people. This change, however, has not been accompanied by an alienation of elderly people from the family, and, notably, not from their children. By and large, elderly people are not left alone and isolated, forgotten in long-term care institutions. When health deteriorates, whether physical, mental, or some combination of the two, the informal network of family and friends tends to provide care." 130/

The primary care giver in the family network is the spouse, usually the wife; the children are secondary care givers. Daughters are more likely to provide hands-on care and emotional support, while sons are more likely to provide supervision and money.

Increased attention has been given in recent years to what has been called the generation in the middle. As life expectancy increases, people live to older ages and their health declines seriously only later in life. The result is that, in some cases, the children, primarily daughters, who give the care are in the later years of middle age or even elderly themselves. In other cases, the women giving the care still face demands from their own children and from their spouses and must continue to perform domestic chores. At the same time as they are returning in large number to the paid labour force they are often adding parent care to their already long list of responsibilities. 131/, 132/

There is increasing evidence of the stress that arises from the giving of care. Depression, psychological stress, less satisfaction with life, declines in health and adverse effects on leisure and family activities have all been reported in recent research, which is reviewed in 133/. Governments have been slow to recognize that successful care giving from non-governmental sources such as the family requires that support and services be provided to the care givers themselves. Research clearly shows that without such support, informal care mechanisms break down more quickly, often forcing the Government to assume the whole responsibility, usually at greater cost. One kind of support is respite care, which provides care givers with access to non-family service providers on a temporary basis, giving them time off and relieving their stress.

In some countries there is increasing recognition on the part of employers that many of their employees, especially women, are under great stress as a result of the care responsibilities they must assume over and above the demands of their paid jobs. A number are beginning to develop employment policies that will respond to this issue, not only for humanitarian reasons but also out of self-interest, seeking to maintain worker productivity.

E. Special problems require special solutions

It is not sufficient to promote the equal treatment of men and women and to develop so-called sex-neutral laws. There is also a need to recognize the biological differences between men and women and the role differences that continue to govern behaviour. Looking at one group of women, older women, it can be seen that they do indeed have special problems related to employment, income adequacy, health and their care giving responsibilities. Such problems, and others, suggest that each country should carefully review the options for dealing with the special needs of older women.* Not only would this promote greater equity between the sexes, but it also promises to improve the general welfare of both men and women as they grow older.

F. Country examples

1. Kenya: older women and self-help**

It is often said that older people in Africa are looked after by traditional family structures. However, sometimes these structures are weakened or missing altogether. HelpAge Kenya, with financial support from the United Nations Trust Fund for Aging, is supporting a community where a group of older women are facing just this problem.

---

*The main area where action has been taken is various family provisions in old age insurance programmes. Many countries have special spouse benefits and earlier retirement ages for women. Three countries, Germany, France and Canada, provide for certain periods associated with child-bearing to be counted as years of work when calculating benefit levels.

**The discussion that follows describes a project financed by the United Nations Trust Fund for Aging, as reported by HelpAge International. 134/

The Shimba Hills are a lush, fruit-growing region in Kenya's Coast Province. It was the fertility of the region that attracted many to settle there in the drought years 1959 and 1960. The settlers were often married couples who left their extended families behind. These early settlers are now growing older, and most of their own children have left to look for work in coastal towns such as Mombasa and Malindi. In the village of Kichakasimba, some 10 years ago, a group of women settlers first got together to tackle the problem of earning income for their later years. Thus began Itambya Yaa Aka Kichakasimba ("women of Kichakasimba take a step ahead").

Lacking family networks in the area, many of the women face a future with little or no support, and the group has concentrated on maintaining its members' independence within the community. One of the first activities was a scheme for safe and clean water. A more recent activity is a poultry-keeping project, which aims to provide income for members from the sale of chickens and eggs, both locally and to the flourishing tourist hotels of the Kenya Coast. A stock of chickens was bought in 1989 with a grant from the United Nations Trust Fund for Aging. The grant also provided money for materials with which the women built housing for the poultry.

Project management is entirely in the hands of the women. They organize quotas for the collection of water, feeding and overnight guard duties; all take their turn at these tasks. Problems are many, and funds are scarce, despite the assistance from the United Nations. However, on-site training by HelpAge Kenya staff in basic management techniques is helping the project to move forward. In the last analysis, however, says HelpAge Kenya's Project Officer Robert Ekongot, "It is the morale, commitment and hard work of the group which are the key to the project's success".

2. Canada: helping widows

Statistics Canada estimated, in the early 1980s, that about one third of Canadian women aged 65 or over had incomes below the government-defined poverty level. This contrasts with a 19 per cent poverty rate for older men. Moreover, among unmarried older women the poverty rate was measured at about 62 per cent. 135/ Many of these women were widowed.

The economic problems of unmarried women have improved somewhat in recent years, with poverty rates declining from 62 per cent to 43 per cent in 1986. 136/ This improvement undoubtedly reflects continued improvement in government income maintenance programmes and, to a lesser extent, improvements in occupational pensions.

The main sources of income for the poor elderly, i.e. those aged 65 or over, in Canada are (a) the Old Age Security pension paid to all elderly individuals who meet the age and residence requirement, (b) the means-tested Guaranteed Income Supplement and (c) provincial monetary supplements, available in all but four provinces.* However, these programmes, which are geared to people after age 64, do not help women whose husbands die before age 65.

---

*The Canadian/Quebec Pension Plan is an important source of income for many retired elderly workers. However, the three programmes mentioned provide about 90 per cent of the income for the poor elderly.

In an effort to help women in the transitional period between the middle years and old age, the Canadian government established a Spouse Allowance in 1975 and a Widowed Spouse Allowance in 1985. The Spouse Allowance was enacted to assist older couples who had to meet the basic needs of both spouses when only one was eligible for age 65+ benefits; it is paid to eligible spouses aged 60-64 married to persioners.

The Widowed Spouse Allowance was enacted as a transitional benefit to help people threatened financially by widowhood who did not yet qualify for a pension. The Widowed Spouse Allowance assists widowed persons aged 60-64 whose income is below a specified ceiling. In May 1988, the maximum benefit payable was 613.33 Canadian dollars; the benefit is price-indexed quarterly.*

In addition to the national legislation, the Province of Alberta has enacted the Widows' Pension Act to help those in the transitional years. This means-tested allowance is available to Alberta widows and widowers aged 55-64 who meet the citizenship and residency requirements. The Alberta programme for widows provides a monthly pension as well as premium-free Alberta Health Care Insurance, extended health benefit and a property education tax reduction or its equivalent, and the recipients are eligible for home improvement and home heating grants.

As Gee and Kimball observe about women in Canada, "elderly women are not poor because they are old; they are poor because they are women who outlive their husbands". 137/ It is this realization that has encouraged past legislation in Canada, briefly summarized above, and that encourages the continuing attention being given to the special economic problems of women in Canada today.

---

*The exclusion of the never-married and the divorced from benefits is currently being challenged in the Canadian courts.

VI. COMBATING THE CALAMITY OF BLINDNESS WITH AGE

When the health problems of the elderly are being considered, it is common to think at first about the major diseases that threaten the elderly, diseases that often play a deciding role in their death. Table 10 shows the five leading causes of death in the Americas, with heart disease and cancer ranking first and second. Data on the causes of death in developing regions of the world, other than in the Americas, are extremely limited. However, on the basis of existing reports, it would appear that infections and parasitic diseases are the leading causes of death in Africa among older people. "The situation in developing Asian countries is mixed: in the Philippines, for example, communicable diseases are said to be a slightly greater cause of death than cardiovascular diseases at ages 60-64, but thereafter cardiovascular diseases are more important." 138/

Table 10. Leading causes of death among older persons in the Americas, by rank order a/

Cause of death	North America	Middle America	Caribbean	South America
Heart disease	1	1	1	1
Malignant neoplasms	2	3	2	2
Cerebrovascular disease	3	4	3	3
Influenza and pneumonia	3	4	4	4
Diabetes mellitus or accidents	5	5	5	5

Source: Based on data in Pan American Health Organization, Health Conditions in the Americas, 1977-1980 (Washington, D.C., 1982), as reported in Kevin Kinsella, Aging in the Third World, International Population Reports Series P-95, No. 79 (Washington, D.C., Government Printing Office, 1988).

a/ Data are for persons aged 65 or over around 1979.

Turning from those conditions that cause death to the general health status of the elderly, a somewhat different picture of their health problems emerges. Table 11 shows the incidence of various health problems among the population aged 65 and over in the United States. Again, cardiac problems are the most frequent problems. However, in contrast to the data on the ranked causes of death, problems of hearing and vision impairment top the list after hypertension and heart conditions.

A 1982 study of the health problems of the elderly in the German Democratic Republic, Hungary, the USSR and Yugoslavia also reported that the most common problem of the elderly in those countries was cardiovascular disease. 139/ Second to cardiovascular diseases were diseases of the respiratory system.* In Hungary, for example, bronchitis, emphysema or

*Hearing and visual problems were not included in the study.

asthma afflicted 81 out of every 1,000 men in the survey sample and 34 out of every 1,000 women.

Table 11. Prevalence of selected impairments in the United States, 1981 a/

Condition	Prevalence of impairment (number of people affected per 1,000 population)	
	Age 65 or over	All ages
Hypertensive disease	379	113
Hearing impairment	284	83
Heart conditions	277	76
Visual impairment	137	83
Diabetes	85	24
Urinary system disease	57	26
Chronic bronchitis	46	35
Cerebrovascular disease	45	8

Source: United States, National Center for Health Statistics, Health, United States (Washington, D.C., Government Printing Office, 1981), as reported in Committee on Chemical Toxicity and Aging, Aging in Today's Environment (Washington, D.C., National Academy Press, 1987), table 6-3.

a/ Based on household interviews of non-institutionalized civilians.

A. Re-evaluating health care priorities

"Typically, the least developed countries spend 60 to 80 per cent of public health budgets on urban hospitals even though only a small fraction of the population will ever need hospital services, and despite the fact that 80 per cent live in rural areas, well beyond the reach of the costliest facilities." 140/ While hospitals are needed in every country, such high-cost institutions and disease-oriented medicine threaten to consume most of a developing country's meagre health resources and leave the bulk of health problems unattended. This general problem of health expenditure priorities is as relevant to the more narrow case of the health problems of older people.

With older age comes an increasing incidence of health problems of various kinds. To date, much of the attention of the geriatric community has been on epidemiological, i.e. disease, issues related to the ageing process and the elderly. 141/ In recent years, however, increased attention has been given to a wider range of medical issues. 142/ In 1987, WHO, which has undertaken a number of pioneering projects in the ageing field, established, in conjunction with the United States National Institute on Aging, a special programme for research on ageing that encompasses a broad range of issues. Four areas of research were given priority: healthy ageing; dementias of ageing; nutrition, with an emphasis on osteoporosis; and immune functions. 143/

It is important to give attention to the most pressing and treatable health problems confronting the elderly throughout the world, which are found in survey after survey, especially in developing countries, to be problems related to cardiac function, hearing, teeth, diabetes and visual impairment.

In a survey of Nigerians, approximately half of those aged 60 and over reported problems of general physical weakness and approximately one third reported vision problems. 144/ In the rural areas, bending problems and arthritis were cited by over 40 per cent of the sample.

A study of four countries in the western Pacific confirms the findings of other surveys regarding the high incidence of vision problems among the elderly in developing countries. Table 12 shows that between 31 and 82 per cent of the elderly in the four countries, depending on the sex and the country, had general problems with vision; between 9 and 59 per cent had evidence of cataract. While this survey determination of cataract problems may not reflect true differences among the elderly in the four countries (see table 12), the data are a good indication of the overall magnitude and seriousness of the cataract problem in all developing countries.

Table 12. Vision problems of the elderly in Fiji, Malaysia, the Philippines and the Republic of Korea a/
(Percentage of the elderly affected)

Country	General sight problems	Evidence of cataract b/
Fiji		
Both sexes	73	47
Females	71	48
Males	75	45
Malaysia		
Both sexes	68	57
Females	68	54
Males	65	59
Philippines		
Both sexes	81	22
Females	82	21
Males	79	21
Republic of Korea		
Both sexes	33	10
Females	34	9
Males	31	11

Source: Based on data in G. R. Andrews and others, Aging in the Western Pacific (Manila, World Health Organization, Regional Office for the Western Pacific, 1986), table 24.

a/ Persons aged 60 and over were surveyed in 1984. General vision problems were detected using a simple sight test administered by the interviewers, which included a simple test to detect cataracts.

b/ Variations in the incidence of cataract detected in the four countries may result, in part, from differences in examination technique or observer skill.